BPHC Technical Assistance Web Guide for Grantees

The BPHC Technical Assistance Web Guide for Grantees (TA guide) is a self-assessment tool designed to help new BPHC grantees provide high-quality primary health care from the day they open their doors for business. The TA guide is a central hub of Federal policies, programs, and resources intended for the specific needs of health centers working within the Health Center Program requirements.

BPHC's Office of Quality Improvement/Strategic Partnerships Division developed the TA guide available at
http://bphc.hrsa.gov/qualityimprovement/newguide.html

Developed by:
The U.S. Department of Health and Human Services (HHS)
Health Resources and Services Administration (HRSA)
Bureau of Primary Health Care (BPHC)
Office of Quality Improvement (OQI)

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Developed by the Health Resources and Services Administration
Last Updated: May 2015

Introduction

Welcome to the BPHC Technical Assistance Web Guide for Grantees!

Purpose

BPHC designed this TA guide to assist newly funded Health Center Program grantees in their efforts to maintain compliance with BPHC program requirements and establish an organizational culture committed to continuous quality improvement and the delivery of high quality, effective, and safe patient care.

While BPHC primarily developed the TA guide with newly funded health centers in mind, much of the content may be beneficial to existing Health Center Program grantees and look-alikes (http://bphc.hrsa.gov/programopportunities/lookalike/index.html) as well.

The TA guide addresses:
- Establishing key contacts
- Setting up and receiving key payment streams
- Providing primary care services required of BPHC grantees
- Maintaining health center management and finance
- Ensuring health center governance

TA Guide Content and Structure

Documents to be Reviewed in Conjunction with the TA Guide
- New Access Point grant application and Notice of Award (NoA)—these are the documents that define the scope of project you have agreed to carry out as a BPHC grantee.
- The Electronic Handbooks (EHB) user guide (http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP/napfy2015userguide.pdf) for New Access Point grantees
  - A good reference for helping new and existing grantees navigate the electronic system for official submissions to HRSA
  - Specific EHB reference materials and assistance are available to help new and existing grantees navigate the electronic system to submit official submissions to HRSA by contacting the BPHC Helpline at http://www.hrsa.gov/about/contact/bphc.aspx or 1-877-974-2742.

TA Guide Resources
This TA guide offers information and resources to access:
- Federal programs intended to benefit and support health centers
- Suggested program practices
- Printable questions to assist with self-assessments
- Links to sample documents, information pages, and policy information

Program Notices
BPHC communicates to grantees about policies related to the Health Center Program through Policy Information Notices (PINs) and Program Assistance Letters (PALs):
- PINs define and clarify policies and procedures that grantees funded under section 330 of the Public Health Service Act must follow.

- PALs summarize and explain items of significance for health centers, including for example, HRSA program implementation activities, recently enacted laws, final regulations, and/or new HHS initiatives.

Self-Assessments
There are over 30 sets of questions derived from the Health Center Program Site Visit Guide (http://bphc.hrsa.gov/programrequirements/centerguide.html) for each of the 19 Health Center Program Requirements.

For a useful guide to HRSA-related terminology, go to http://www.hrsa.gov/grants/apply/assistance/NAP/definitions.pdf.

Contacts

This section covers key contacts and resources that may be of assistance to you as a BPHC grantee. The breadth of contacts covered ranges from your project officer, to state-level organizations, and useful websites.

BPHC Health Center Program Project Officer (PO)

Contact Your Health Center Program PO
Your NoA lists your Health Center Program Project Officer (PO), who is your primary point of contact for programmatic issues:
- Health Center Program requirements
- Technical assistance needs
- Understanding clinical and financial measures and their contributing/restricting factors
- Any possible changes to proposed activities in the approved application

Note: Your Project Officer also will contact you soon after you receive your NoA and will want to set up periodic calls.

Locate Key Documents Prior to Talking to your PO
- Bylaws
- Articles of Incorporation
- Most recent NoA
- Most recent Health Center Program grant application
- Most recent strategic plan
- Most recent financials

Key Initial Discussion Points with your PO
- Confirm the timing of your Federal funding (Project and Budget Period start dates/end dates).
- Confirm when the next Federal grant application is due, and whether it is competitive [Service Area Competition (SAC)] or a progress report [Budget Period Progress Report (BPR)].
- Discuss program and grant conditions that are listed in your NoA.
- Set up times to communicate with your Project Officer periodically (e.g., monthly, quarterly) to keep each other posted on developments.

HRSA Grants Management Specialist (GMS)

Contact Your Grants Management Specialist
Listed on your NoA, your Grants Management Specialist (GMS) is your point for contact for matters related to administrative management of your grant:
- Drawdown of funding
- Federal payment management systems
- Regular financial reporting

Your GMS also may participate on the introductory call your Project Officer sets up soon after you receive your NoA.
- Prior to the call, review HRSA's Grants Management Workshop (October 2010) materials (http://www.hrsa.gov/grants/manage/workshop.html) that cover management of your grant,

reporting requirements, Electronic Handbooks overview, terms and conditions, and other aspects of HHS/HRSA grants management.
- During the call, confirm details and conditions noted on your NoA or any potential requests that may involve significant changes to the most recent approved budget.

Official Points of Contact in Grants.Gov and EHB
- Send a letter or email to your PO and GMS requesting an official change of contact in Grants.gov for any Federal government grants you have.
    - o This includes setting staff permissions to register work on specific grant functions.
    - o You will need prior approval from your PO to change your profile as an Authorizing Organization Representative (AOR).
- Pay particular attention to maintaining current contact information in EHB for your organization.
- Ensure you have at least two individuals in your organization registered in EHB who can access and submit documents as needed if the Authorizing Official Representative is unable or absent.
- Contact System for Award Management (SAM) at https://www.sam.gov/portal/SAM/#1 once awarded to make changes such as organizational name and address changes that are to be reflected in EHB.
- For more information on EHB, please contact the BPHC Helpline at http://www.hrsa.gov/about/contact/bphc.aspx or 1-877-974-BPHC (2742), 8:30 a.m. to 5:30 p.m. ET, Monday through Friday (except Federal holidays).

Key State-Level Resources

State Primary Care Office (PCO)
PCOs (http://bhpr.hrsa.gov/shortage/hpsas/primarycareoffices.html) are state-level offices that work to improve access to health care services for residents of their State. PCOs are responsible for shortage designations. They know providers and sites in their State, including National Health Service Corps (NHSC) approved sites. Some States also have recruitment assistance (including J1 Visa Waivers) and State primary care grant resources. PCOs can help:
- Health centers and look-alikes connect with primary care providers seeking jobs at NHSC-approved sites in their State
- Free clinics complete the NHSC site application for a new or satellite site

State Primary Care Association (PCA)
State/Regional PCAs (http://bphc.hrsa.gov/qualityimprovement/supportnetworks/ncapca/associations.html) are private, non-profit organizations that BPHC funds to:
- Provide training and technical assistance to health centers and other safety-net providers
- Support the development of health centers in their State
- Enhance the operations and performance of health centers
- Offer assistance with understanding/implementing program requirements such as governance, grants management, clinical or quality improvement support
- Training or orientation of new staff, and answering general questions
Consider asking your PCA about mentoring opportunities with other health centers in your State or region.

General HRSA/BPHC Resources

BPHC Primary Health Care Digest
BPHC publishes a weekly, electronic edition of the Primary Health Care Digest that provides information on upcoming funding opportunities, training and technical assistance sessions, and useful information from Federal and non-Federal resources.
- Sign up for the Digest at https://public.govdelivery.com/accounts/USHHSHRSA/subscriber/new?topic_id=USHHSHRSA_118
- Contact phcdigest@hrsa.gov if you have trouble receiving the Digest.

BPHC Helpline
The BPHC Helpline can assist with: BPHC grant and cooperative agreement funding opportunities; Uniform Data System (UDS); Change in Scope (CIS); and Federal Tort Claims Act (FTCA) coverage, deeming/redeeming, and claims.
- http://www.hrsa.gov/about/contact/bphc.aspx
- 1-877-974-BPHC (2742), 8:30 a.m. to 5:30 p.m. ET, Monday through Friday (except Federal holidays)

The Health Resources and Services Administration (HRSA) Health Center Program Website
(http://bphc.hrsa.gov/)
The website gives HRSA a unified point-of-entry for all BPHC program-related content including all of BPHC's special initiatives. You can access technical assistance by topic under these top-level categories:
- Health Center Program Requirements
- Health Center Quality Improvement
- Program Opportunities
- Health Center Data and Reporting
- Federal Tort Claims Act (FTCA)
- About Health Centers

General HRSA Help
The HRSA Contact Center can assist with: EHB login/security issues, creating EHB accounts, username/password issues, and EHB roles and/or privileges.
- Callcenter@HRSA.gov
- 1-877-464-4772, 9 a.m. to 5:30 p.m. ET, Monday through Friday (except Federal holidays)

Accessing Program Funds

This section provides a brief overview of the steps needed to enable your health center to be reimbursed by HRSA for your Health Center Program grant activities, as well as Medicare and Medicaid under the FQHC payment system. Detailed information on Medicare reimbursement is available in PAL 2011-04: Process for Becoming Eligible for Medicare Reimbursement under the FQHC Benefit (http://bphc.hrsa.gov/programrequirements/policies/pal201104.html).

Understanding Your NoA

Importance of Reading and Understanding Your NoA
The NoA is the official document that states the terms, conditions, and amount of an award. The Grants Management Officer (GMO), who is authorized to obligate funds on behalf of the HRSA, signs your NoA.
- HRSA issues an NoA, showing the amount of Federal funds authorized for obligation and any future-year commitments, for each budget period in the approved project period.
- HRSA emails copies of the NoA to each successful applicant. Copies may be sent to either the Authorized Representative or the Program Director.

NoA Sections
Notice of Award Form Page 1:
- Sections 1–8 include basic information about the grant award including the date issued, CFDA number, award number, grant number, project period, and budget period.
- Sections 9 and 10 list the grantee name and address and the name of the Program Director.
- Sections 11–14 outline budget information.
- Section 15 lists the amount of non-Federal funds in support of the project.
- Section 17 outlines the future support amount of the final project period.

Notice of Award Form Pages 2–4:
- Page 2 provides instructions on how to access the Electronic Handbooks (EHB) and outlines the applicable terms and conditions of the award.
- Page 3 outlines reporting requirements and provides due dates and explanations for required reports.
- Page 4 lists the contact information for the grantee's HRSA assigned Project Officer and Grants Management Specialist.

Links and Additional Resources
- HRSA NoA Summary (http://www.hrsa.gov/grants/manage/awardmanagement/notice/printnotice.pdf)
- HRSA Awards Management Tutorial FAQs (http://www.hrsa.gov/grants/manage/awardmanagement/faqs.html)

Sample NoA

Below is a sample NOA. Please note that the NoA is not necessarily 4 pages; its actual length depends on the number of conditions placed on the award by BPHC. Callout boxes point to important elements of the NoA.

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Instructions to access EHBs

HRSA Electronic Handbooks (EHBs) Registration Requirements

The Project Director of the grant (listed on this NGA) and the Authorizing Official of the grantee organization are required to register (if not already registered) within HRSA's Electronic Handbooks (EHBs). Registration within HRSA EHBs is required only once for each user for each organization they represent. To complete the registration quickly and efficiently we recommend that you note the 10-digit grant number from box 4b of this NGA. After you have completed the initial registration steps (i.e., created an individual account and associated it with the correct grantee organization record), be sure to add this grant to your portfolio. This registration in HRSA EHBs is required for submission of noncompeting continuation applications. In addition, you can also use HRSA EHBs to perform other activities such as updating addresses, updating email addresses and submitting certain deliverables electronically. Visit https://grants.hrsa.gov/webexternal/login.asp to use the system. Additional help is available online and/or from the HRSA Call Center at 877-Go4-HRSA/877-464-4772;301-998-7373.

Terms and Conditions

Applicable terms and conditions of award.

Failure to comply with the special remarks and condition(s) may result in a draw down restriction being placed on your Payment Management System account or denial of future funding.

Grant Specific Term(s)

1.

   It is mandatory for each project to budget for 10 person trips (Number of persons as appropriate per meeting; 3 to 4 meetings per year) to attend MCHB sponsored Healthy Start-related meetings in the Washington DC or designated locale throughout the year.

2. Healthy Start funds may not be used for entertainment costs. Trips and/or activities for Healthy Start clients must relate to both the goal of reducing infant mortality and the approved project objectives.

3. Fund raising costs are unallowable. Healthy Start funds, e.g., staff salary, contract personnel, consultants or costs for items to be sold or raffled, may not be used for fund raising activities.

4. The replacement of, or significant change in the responsibilities of senior project staff, including the project director, project manager, and chief financial officer, must have prior approval from the Grants Management Officer. The grantee must obtain prior approval from the awarding office for changes in scope, direction, type of service delivery or training, and rebudgeting of Healthy Start funds.

5. This Notice of Grant Award provides the offset of an unobligated balance in the amount of $ ▇▇▇▇ from the 06/01/2009 - 05/31/2010 budget period to the current budget period. Please be advised that if the final resolution of the audit determines that the unobligated balance of Federal Funds is incorrect, HRSA is not obligated to make additional Federal Funds available to cover the shortfall.

Program Specific Term(s)

1. The management Team, including key personnel, must reflect the cultural diversity of the Community to be served.

2. Each project is expected to establish a plan to recover, to the maximum extent feasible, third party revenues to which it is entitled for services provided; garner all other available Federal, state, local, and private funds; and charge beneficiaries according to their ability to pay for services without creating a barrier to those services. Where third-party payors, including Government agencies, are authorized or are under legal obligation to pay all or a portion of charges for health care services, "all such sources must be billed for covered services, and every effort must be made to obtain payment. Each service provider receiving Federal funds, either directly or indirectly, must have a procedure to identify all persons served who are eligible for third-party reimbursement."

3. All MCHB discretionary grant projects are expected to incorporate a carefully designed and well-planned evaluation protocol capable of demonstrating and documenting measurable progress toward achieving the stated goals. The measurement of progress toward goals should focus on systems, health and performance indicators, rather than solely on the intermediate process measures.

4. In accordance with the requirements of the "Government Performance and Results Act (GPRA) of 1993" (Public Law 103-62), MCHB has established measurable goals for Federal programs that can be reported as part of the budgetary process, thus linking funding decisions with performance. Performance measures and data elements for all MCHB-funded grant programs including Healthy Start have been finalized. As previously communicated all Healthy Start projects are expected to participate in the MCHB reporting requirements system.

Standard Term(s)

1. All discretionary awards issued by HRSA on or after October 1, 2006, are subject to the HHS Grants Policy Statement (HHS GPS) unless otherwise noted in the Notice of Award (NoA). Parts I through III of the HHS GPS are currently available at ftp://ftp.hrsa.gov/grants/hhsgrantspolicystatement.pdf. Please note that the Terms and Conditions explicitly noted in the award and the HHS GPS are in effect.

2. The HHS Appropriations Act requires that when issuing statements, press releases, requests for proposals, bid solicitations, and other documents describing projects or programs funded in whole or in part with Federal money, all grantees receiving Federal funds, including but not limited to State and local governments, shall clearly state the percentage of the total costs of the program or project which will be financed

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with Federal money, the dollar amount of Federal funds for the project or program, and percentage and a dollar amount of the total costs of the project or program that will be financed by nongovernmental sources.

3. Recipients and sub-recipients of Federal funds are subject to the strictures of the Medicare and Medicaid anti-kickback statute (42 U.S.C. 1320a - 7b(b) and should be cognizant of the risk of criminal and administrative liability under this statute, specifically under 42 U.S.C. 1320 7b(b) Illegal remunerations which states, in part, that whoever knowingly and willfully: (A) Solicits or receives (or offers or pays) any remuneration (including kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, in return for referring (or to induce such person to refer) an individual to a person for the furnishing or arranging for the furnishing of any item or service, OR (B) In return for purchasing, leasing, ordering, or recommending purchasing, leasing, or ordering, or to purchase, lease, or order, any goods, facility, services, or item ....For which payment may be made in whole or in part under subchapter XIII of this chapter or a State health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

4. Items that require prior approval from the awarding office as indicated in 45 CFR Part 74.25 [Note: 74.25 (d) HRSA has not waived cost-related or administrative prior approvals for recipients unless specifically stated on this Notice of Grant Award] or 45 CFR Part 92.30 must be submitted in writing to the Grants Management Officer (GMO). Only responses to prior approval requests signed by the GMO are considered valid. Grantees who take action on the basis of responses from other officials do so at their own risk. Such responses will not be considered binding by or upon the HRSA.
In addition to the prior approval requirements identified in Part 74.25, HRSA requires grantees to seek prior approval for significant rebudgeting of project costs. Significant rebudgeting occurs when, under a grant where the Federal share exceeds $100,000, cumulative transfers among direct cost budget categories for the current budget period exceed 25 percent of the total approved budget (inclusive of direct and indirect costs and Federal funds and required matching or cost sharing) for that budget period or $250,000, whichever is less. For example, under a grant in which the Federal share for a budget period is $200,000, if the total approved budget is $300,000, cumulative changes within that budget period exceeding $75,000 would require prior approval). For recipients subject to 45 CFR Part 92, this requirement is in lieu of that in 45 CFR 92.30(c)(1)(ii) which permits an agency to require prior approval for specified cumulative transfers within a grantee's approved budget. [Note, even if a grantee's proposed rebudgeting of costs falls below the significant rebudgeting threshold identified above, grantees are still required to request prior approval, if some or all of the rebudgeting reflects either a change in scope, a proposed purchase of a unit of equipment exceeding $25,000 (if not included in the approved application) or other prior approval action identified in Parts 74.25 and 92.30 unless HRSA has specifically exempted the grantee from the requirement(s).]

5. Payments under this award will be made available through the DHHS Payment Management System (PMS). PMS is administered by the Division of Payment Management, Financial Management Services, Program Support Center, which will forward instructions for obtaining payments. Inquiries regarding payments should be directed to: ONE-DHHS Help Desk for PMS Support at 1-877-614-5533 or PMSSupport@psc.hhs.gov. For additional information please visit the Division of Payment Management Website at www.DPM.PSC.GOV.

6. The DHHS Inspector General maintains a toll-free hotline for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements. Such reports are kept confidential and callers may decline to give their names if they choose to remain anonymous. Contact: Office of Inspector General, Department of Health and Human Services, Attention: HOTLINE, 330 Independence Avenue Southwest, Cohen Building, Room 5140, Washington, D. C. 20201, Email: Htips@os.dhhs.gov or Telephone: 1-800-447-8477 (1-800-HHS-TIPS).

7. Submit audits, if required, in accordance with OMB Circular A-133, to: Federal Audit Clearinghouse Bureau of the Census 1201 East 10th Street Jefferson, IN 47132 PHONE: (310) 457-1551, (800)253-0696 toll free http://harvester.census.gov/sac/facconta.htm

8. EO 13166, August 11, 2000, requires recipients receiving Federal financial assistance to take steps to ensure that people with limited English proficiency can meaningfully access health and social services. A program of language assistance should provide for effective communication between the service provider and the person with limited English proficiency to facilitate participation in, and meaningful access to, services. The obligations of recipients are explained on the OCR website at http://www.hhs.gov/ocr/lep/revisedlep.html.

9. This award is subject to the requirements of Section 106 (g) of the Trafficking Victims Protection Act of 2000,as amended (22 U.S.C. 7104). For the full text of the award term, go to http://www.hrsa.gov/grants/trafficking.htm. If you are unable to access this link, please contact the Grants Management Specialist identified in this Notice of Grant Award to obtain a copy of the Term.

Reporting Requirement(s)

1. **Due Date: Within 90 Days of Award Issue Date**
The grantee must submit a Performance Report within 90 days after receipt of the NGA. This report should include completing the financial forms, project abstract, grant summary and performance measures. The performance report must be submitted using the Electronic Handbook (EHB).

2. **Due Date: 10/30/2012** [Due dates and explanations for required reports]
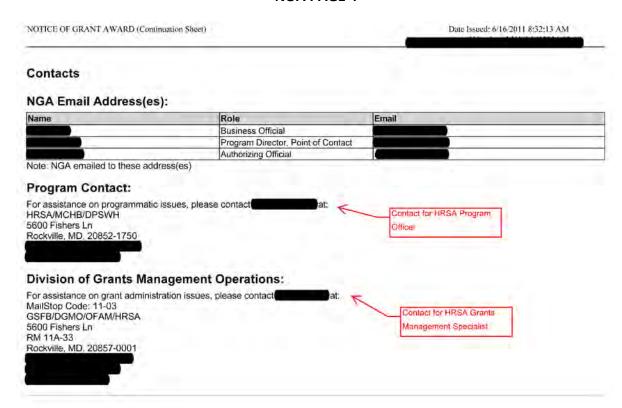The grantee must submit a Federal Financial Report (FFR) no later than October 30, 2012. The report should reflect cumulative reporting within the project period and must be submitted using the Electronic Handbooks (EHBs).

Failure to comply with these reporting requirements will result in deferral or additional restrictions of future funding decisions.

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Contacts

NGA Email Address(es):

Name	Role	Email
▮▮▮▮	Business Official	▮▮▮▮
▮▮▮▮	Program Director, Point of Contact	▮▮▮▮
▮▮▮▮	Authorizing Official	▮▮▮▮

Note: NGA emailed to these address(es)

Program Contact:

For assistance on programmatic issues, please contact ▮▮▮▮ at:
HRSA/MCHB/DPSWH
5600 Fishers Ln
Rockville, MD. 20852-1750
▮▮▮▮

Contact for HRSA Program Officer

Division of Grants Management Operations:

For assistance on grant administration issues, please contact ▮▮▮▮ at:
MailStop Code: 11-03
GSFB/DGMO/OFAM/HRSA
5600 Fishers Ln
RM 11A-33
Rockville, MD. 20857-0001
▮▮▮▮

Contact for HRSA Grants Management Specialist

Receiving HRSA Funds

Enroll in the HHS Payment Management System (PMS)
Payment of grants to grantees occurs through the HHS PMS (http://www.dpm.psc.gov/), a fully automated and full-service, centralized grants payment and cash management system.
- Contact your GMS, listed on your NoA, to begin setting up your PMS account.

Review Financials
Federal funding should not sit in an interest-bearing account for more than 72 hours.
- Ensure you are on schedule to draw down and obligate Federal funding, as approved, prior to the conclusion of the grant period.
- Refer to Uniform Administrative Requirements for HHS Awards (45 CFR 75) (http://www.ecfr.gov/cgi-bin/text-idx?SID=e9e43be8e59e0a85f4ac8ee5b8ef7716&node=pt45.1.75&rgn=div5) and/or consult your GMS for additional information.

Medicare and Medicaid's Reimbursement Systems for Federally Qualified Health Centers (FQHCs)
A health center must apply to enroll in each program as an FQHC; this application must be approved before payment under the FQHC system begins.

Under Medicare (and many State Medicaid programs), payment as an FQHC is not retroactive to services provided prior to the date the application was approved. For these services, health centers may bill Medicare under the name of individual providers, and will be reimbursed based on traditional payment systems (e.g., the physician fee schedule under Medicare).

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Note: Being approved for a health center grant through section 330 or receiving a designation as a Health Center Program look-alike is not sufficient for a health center to be reimbursed under the FQHC payment system.

Payment Structure
Both Medicare and Medicaid have payment systems that are unique to FQHCs. These systems are designed to reflect the relatively higher intensity of health center patients and the broader range of services that health centers provide.

Payment is made on a per-visit basis, meaning that FQHCs receive a standardized, predetermined amount for each visit, regardless of which services were actually provided.

Enrolling and Billing Under Medicare

How to prepare and submit a Medicare Enrollment Application
For information on how to prepare and where to submit a Medicare enrollment application, see PAL 2011-04: Process for Becoming Eligible for Medicare Reimbursement under the FQHC Benefit (http://bphc.hrsa.gov/programrequirements/policies/pal201104.html).

Importance of prompt submission of Medicare enrollment application
Reimbursement under the Medicare FQHC system does not begin until the date the enrollment application is approved.
- HRSA strongly advises health centers to submit this application as soon as possible and to remain in regular contact with the Medicare contractor about how the review process is progressing.

Medicare regulations state that health centers must be operational on the date that they submit the enrollment application.
- HRSA strongly encourages health centers to have the application ready for submission on the first day the site becomes operational.

Each permanent and seasonal site must be enrolled individually
Medicare considers each permanent and seasonal health center site to be a unique FQHC. Therefore, each site must enroll individually and receive a unique Medicare Billing Number.

Billing under the FQHC per-visit payment system
Once it has been approved as an FQHC, a health center submits claims to its Medicare contractor using CMS Form UB-04, which must be submitted electronically.

How Medicare per-visit payment rates are set
- Initially, a Medicare contractor will assign an FQHC an "interim per visit rate" based on an estimate of its costs for caring for Medicare patients.
- At the end of the first fiscal year, the FQHC files a "Medicare Cost Report" which reports its actual costs.
- The Medicare contractor reviews this report and determines a per visit rate.
  - The rate adjusts downward if the individual providers did not meet productivity standards, and/or if the rate exceeds the Upper Payment Limits established by the Centers for Medicare & Medicaid Services (CMS).
  - Total amount due is based on this final rate, and compared to the amount actually paid.

- If the amount paid was less than the amount owed, the Medicare contractor pays the difference to the FQHC.
- If the amount due is less than the amount already paid, then the FQHC must repay the Medicare contractor.
  - HRSA encourages new FQHCs to closely monitor their costs versus per visit rates throughout their first year, as they could either owe or receive a potentially large amounts based on this adjustment.
- Once the first cost report is submitted and accepted, the rate determined based on that report will be used in the following year, with another adjustment being made (if necessary) after the year is over.

Reimbursement for Medicare Advantage (Managed Care) Patients

FQHCs are guaranteed to receive their full per-visit rate for their Medicare patients who participate in managed care plans. In these situations, the FQHC negotiates payment rates directly with the Managed Care Organization (MCO), and receives reimbursement directly from the MCO. The FQHC must then bill Medicare for the difference between what the MCO paid and how much it would have received under the standard per-visit payment system. This amount is called the "wrap-around" payment, and Medicare contractors are required to make these payments not less often than every 3 months.

Enrolling and Billing Under Medicaid

Enrolling in Medicaid

Each State Medicaid program establishes its own policies about how health centers are to enroll, and when reimbursement under the FQHC system begins. Many States require a health center to be approved by Medicare as an FQHC before it can apply to Medicaid. Some States make payments under the FQHC system retroactive to the date the health center applied or became operational, while others make no retroactive adjustments.

- To determine the policies in your State, contact your State Medicaid Office (http://www.medicaid.gov/medicaid-chip-program-information/by-state/by-state.html) and/or Primary Care Association (http://bphc.hrsa.gov/qualityimprovement/supportnetworks/ncapca/associations.html).

Billing under the Medicaid FQHC per-visit payment system

Each State determines how FQHCs are to bill Medicaid.

- To determine the practices in your State, contact your State Medicaid office and/or Primary Care Association.

How Medicaid payment rates are set

- In most States, the per-visit payment rates made to FQHCs under Medicaid are referred to as "Prospective Payment System" (PPS) rates.
  - For a new FQHC, the base rate is set by the Medicaid office, based on the FQHC's first year costs, the rates in effect for similar FQHCs in the area, or a combination of both.
  - In future years, this base rate is increased annually using CMS' estimate of health care inflation. It is very important that new FQHCs ensure that the initial PPS rates are set appropriately, as once they are established it is very difficult to change them, other than by the annual inflation update.

- State Medicaid programs have the option of using an Alternative Payment Mechanism (APM) instead of PPS. It is important that health centers closely study a proposed APM system before accepting it. For an APM to be permissible, it must:
  - Result in total payments at least as high as under the PPS.
  - Be approved by the health center.

Reimbursement for patients in Medicaid managed care
Similar to Medicare, FQHCs are guaranteed to receive their full per-visit rate for their Medicaid patients who participate in managed care plans. The FQHC negotiates payment rates directly with the Managed Care Organization (MCO); the FQHC bills Medicaid for the difference between what the MCO paid and how much it would have received under the standard per-visit payment system. State Medicaid programs are required to issue these "wrap-around payments" at least once every 4 months.

Additional information about Medicare and Medicaid
See the CMS FQHC website (https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html). It includes additional links to policies, billing/payment, enrollment/recertification, listserv signup, coding, coverage, manuals, and a range of other resources.

Insurance, Fees and Billing
Please refer to PIN 2014-02: Sliding Fee Discount and Related Billing and Collections Program Requirements (http://bphc.hrsa.gov/programrequirements/policies/pin201402.html) for information on establishing:
(1) A schedule of fees for services;
(2) A corresponding schedule of discounts for eligible patients that is adjusted based on the patient's ability to pay (referred to as the sliding fee discount schedule (SFDS) for the purposes of this PIN); and
(3) Governing board-approved policies and the organization's supporting operating procedures, including those around billing and collections.

Develop Accounts Receivable systems and policies
This should be part of a larger Financial Policies and Procedures Manual. The National Association of Community Health Centers (http://www.nachc.org/) and/or your PCA (http://bphc.hrsa.gov/qualityimprovement/supportnetworks/ncapca/associations.html) may have additional TA resources on this topic.

Program Requirements

This section outlines the Program Requirements with which all BPHC grantees much comply. These Program Requirements are divided into four sections:

> Section I: Need
> Section II: Services
> Section III: Management and Finance
> Section IV: Governance

Section I: Need

Program Requirement 1: Needs Assessment

Requirement
Health center demonstrates and documents the needs of its target population, updating its service area, when appropriate.

Documents/Resources to Review
- Most recent needs assessment(s)
- Service Area Map
- UDS patient origin data, or other patient data
- Health center's list of sites with service area zip codes (Form 5B)
- NAP Implementation Plan
- Your grant application's Form 1A: General Information Worksheet (http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP/forms/1ageneralinformation.DOCX) contains information on your proposed target population. This version is for reference purposes only.
- Data Resources for Demonstrating Need for Primary Care Services (http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP/dataresourceguide.pdf) is a guide on how to find, extrapolate, and utilize data to make informed decisions and maintain a good understanding of community needs in your service area.
- UDS Mapper (http://www.udsmapper.org/) is a useful tool for determining service areas and assessing service area overlap. You will need to sign up for a free account.
- The HRSA Geospatial Data Warehouse (http://datawarehouse.hrsa.gov/) contains information and assistance about HRSA's mapping features and the applications to assist you in creating a map of your neighborhood or potential service area.

Related HRSA Resources
- PIN 2007-09: Service Area Overlap: Policy & Process (http://bphc.hrsa.gov/programrequirements/policies/pin200709.html)
- As a self-assessment tool, please refer to the Program Requirement 1: Needs Assessment section, page 2, of the Health Center Program Site Visit Guide (http://bphc.hrsa.gov/programrequirements/centerguide.html).

Section II: Services

Program Requirement 2: Required and Additional Services

Requirement
Health center provides all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals.

Note: Health centers requesting funding to serve homeless individuals and their families must provide substance abuse services among their required services.

Documents/Resources to Review
- Health center's official scope of project for services (Form 5A)
- Clinical practice protocols and/or related policies and/or procedures that support the delivery of health center services
- Contracts, MOAs, MOUs, etc. for services provided via formal written agreements and/or formal written referral arrangements, including general tracking and referral policies and/or procedures
- The Samples and Templates Resource Center[1] Services page (http://bphc.hrsa.gov/programrequirements/resourcecenter/services/index.html)

Related HRSA Resources
- HRSA Culture, Language and Health Literacy Resources (http://www.hrsa.gov/culturalcompetence/index.html)
- Scope of Project information and policies (http://bphc.hrsa.gov/programrequirements/scope.html) including, Form 5A Service Descriptors (http://bphc.hrsa.gov/archive/about/requirements/scope/form5aservicedescriptors.pdf) and Form 5A Column Descriptors (http://bphc.hrsa.gov/archive/about/requirements/scope/form5acolumndescriptors.pdf)
- As a self-assessment tool, please refer to the Program Requirement 2: Required and Additional Services section, page 3, of the Health Center Program Site Visit Guide (http://bphc.hrsa.gov/programrequirements/centerguide.html).

Any findings regarding the structure or availability of a health center's SLIDING FEE DISCOUNT PROGRAM as it relates to the SERVICES listed on Form 5A (e.g., health center is providing an additional service directly, but the service is NOT discounted through the health center's sliding fee discount program) must be documented under PROGRAM REQUIREMENT 7: SLIDING FEE DISCOUNTS.

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Program Requirement 3: Staffing Requirement

Requirement
Health center maintains a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately licensed, credentialed, and privileged.

Documents/Resources to Review
- Staffing Profile
- Provider contracts, agreements, and any subrecipient arrangement related to staffing (as applicable)
- Credentialing and privileging policies and/or procedures
- Documentation of provider licensure or certification for all licensed or certified health center practitioners
- Privileging lists
- Your grant application's Form 2: Proposed Staffing Profile (http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP/forms/2staffingprofile.docx) contains information on your proposed staffing plan. This version is for reference purposes only.
- The Samples and Templates Resource Center[2]
  - Policy Template and Explanation (http://bphc.hrsa.gov/archive/technicalassistance/resourcecenter/general/policytemplateandexplanation.pdf)
  - Personnel documents (http://bphc.hrsa.gov/programrequirements/resourcecenter/managementandfinance/index.html#Personnel), see
    - Employee Handbook CHC (http://bphc.hrsa.gov/archive/technicalassistance/resourcecenter/managementandfinance/employeehandbookchc.pdf)
    - Privileging and Credentialing Checklist (http://bphc.hrsa.gov/archive/technicalassistance/resourcecenter/clinicalservices/privilegingandcredentialingchecklist.pdf)
    - Personnel Policies and Procedures (http://bphc.hrsa.gov/archive/technicalassistance/resourcecenter/managementandfinance/personnelpoliciesandprocedures.pdf)

Related HRSA Resources
- PIN 2002-22: Clarification of Bureau of Primary Health Care Credentialing and Privileging Policy Outlined in Policy Information Notice 2001-16 (http://bphc.hrsa.gov/programrequirements/policies/pin200222.html)
- As a self-assessment tool, please refer to the Program Requirement 3: Staffing section, page 6, of the Health Center Program Site Visit Guide (http://bphc.hrsa.gov/programrequirements/centerguide.html).

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Program Requirement 4: Accessible Hours of Operation/Locations

Requirement
Health center provides services at times and locations that assure accessibility and meet the needs of the population to be served.

Documents/Resources to Review
- Hours of operation for health center sites
- Most recent Form 5B: Service Sites (Note that the form lists only the TOTAL number of hours per week each site is open, not the specific schedule)
- Form 5C: Other Activities/Locations
- Service are map with site locations noted
- The Samples and Template Resource Center[3] Services page (http://bphc.hrsa.gov/programrequirements/resourcecenter/services/index.html)
- UDS Mapper (http://www.udsmapper.org/)

Related HRSA Resources
- Scope of Project information and policies (http://bphc.hrsa.gov/programrequirements/scope.html)
- As a self-assessment tool, please refer to the Program Requirement 4: Accessible Hours of Operation/locations section, page 9, of the Health Center Program Site Visit Guide (http://bphc.hrsa.gov/programrequirements/centerguide.html).

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Program Requirement 5: After Hours Coverage

Requirement
Health center provides professional coverage for medical emergencies during hours when the center is closed.

Documents/Resources to Review
- Health center's after hours coverage policies and/or procedures
- Agreements, systems and/or contracts that support after hours coverage, if applicable
- Most recent Form 5A: Services Provided, see "Coverage for Emergencies During and After Hours"
- Your State PCA
  (http://bphc.hrsa.gov/qualityimprovement/supportnetworks/ncapca/associations.html) may have more information on this topic.
- The Commonwealth Fund article: A.S. O'Malley, D. Samuel, A.M. Bond et al., "After-Hours Care and Its Coordination with Primary Care in the U.S.," *Journal of General Internal Medicine*, published online June 1, 2012. (http://www.commonwealthfund.org/Publications/In-the-Literature/2012/Jul/After-Hours-and-Its-Coordination-with-Primary-Care.aspx)

Related HRSA Resources
- PAL 2011-02: Health Center Collaboration
  (http://bphc.hrsa.gov/programrequirements/policies/pal201102.html)
- Form 5A Service Descriptors
  (http://bphc.hrsa.gov/archive/about/requirements/scope/form5aservicedescriptors.pdf)
- As a self-assessment tool, please refer to the Program Requirement 5: After Hours Coverage section, page 10, of the Health Center Program Site Visit Guide
  (http://bphc.hrsa.gov/programrequirements/centerguide.html).

Program Requirement 6: Hospital Admitting Privileges and Continuum of Care

Requirement
Health center physicians have admitting privileges at one or more referral hospitals, or other arrangements to ensure continuity of care. In cases where hospital arrangements (including admitting privileges and membership) are not possible, the health center must firmly establish arrangements for hospitalization, discharge planning, and patient tracking.

Documents/Resources to Review
- Hospital admitting privileges agreements/documentation
- Most recent Form 5C: Other Activities/Locations (if applicable, hospitals where health center providers have admitting privileges should be noted on the form)
- State PCA (http://bphc.hrsa.gov/qualityimprovement/supportnetworks/ncapca/associations.html)
- The Agency for Healthcare Research and Quality (AHRQ) PCMH Resource Center (http://www.pcmh.ahrq.gov/)

Related HRSA Resources
- HRSA Accreditation and Patient-Centered Medical Home Recognition Initiative (http://bphc.hrsa.gov/qualityimprovement/clinicalquality/accreditation-pcmh/index.html)
- PAL 2011-02: Health Center Collaboration (http://bphc.hrsa.gov/programrequirements/policies/pal201102.html)
- As a self-assessment tool, please refer to the Program Requirement 6: Hospital Admitting Privileges and Continuum of Care section, page 11, of the Health Center Program Site Visit Guide (http://bphc.hrsa.gov/programrequirements/centerguide.html).

Program Requirement 7: Sliding Fee Discounts

Requirement
Health center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay.
- This system must provide a full discount to individuals and families with annual incomes at or below 100% of the Federal poverty guidelines (only nominal fees may be charged) and for those with incomes between 100% and 200% of poverty, fees must be charged in accordance with a sliding discount policy based on family size and income.
- No discounts may be provided to patients with incomes over 200% of the Federal poverty guidelines.
- No patient will be denied health care services due to an individual's inability to pay for such services by the health center, assuring that any fees or payments required by the center for such services will be reduced or waived.

Documents/Resources to Review
- Schedule of fees/charges for all services in scope
- Sliding fee discount schedule (SFDS)/schedule of discounts (often referred to as the "sliding fee scale")
- Policies for the sliding fee discount program
- Supporting operating procedures for the sliding fee discount program
- Sliding fee signage and/or notification methods
- Documents/forms that support the eligibility process for the sliding fee discount program
- Any other supporting documents such as evaluations of the sliding fee discount program or basis for setting nominal changes (Form 5A)
- HHS definitions and measures of poverty, most recent Federal Poverty Guidelines (http://aspe.hhs.gov/poverty/index.cfm)

Related HRSA Resources
- Scope of Project information and policies (http://bphc.hrsa.gov/programrequirements/scope.html)
- PIN 2014-02: Sliding Fee Discount and Related Billing and Collections Program Requirements (http://bphc.hrsa.gov/programrequirements/policies/pin201402.html)
- As a self-assessment tool, please refer to the Program Requirement 7: Sliding Fee Discounts section, page 12, of the Health Center Program Site Visit Guide (http://bphc.hrsa.gov/programrequirements/centerguide.html).

Program Requirement 8: Quality Improvement/Assurance Plan

Requirement
Health center has an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records. The QI/QA program must include:

- A clinical director whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care;
- Periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the health center; and such assessments shall:
  - Be conducted by physicians or by other licensed health professionals under the supervision of physicians;
  - Be based on the systematic collection and evaluation of patient records; and
  - Identify and document the necessity for change in the provision of services by the health center and result in the institution of such change, where indicated.

Documents/Resources to Review
- Quality improvement/quality assurance (QI/QA) related policies and procedures (e.g. incident reporting system, risk management policies, patient safety policies)
- Clinical Director's job description
- Patient confidentiality and medical records policies and/or procedures
- Clinical care policies and Procedures
- Clinical information tracking policies and/or procedures
- The AHRQ Health Care Innovations Exchange (https://innovations.ahrq.gov/) includes evidence based research and tools to help solve clinical quality and patient care process problems.
- The AHRQ Center for Evidence and Practice Improvement (CEPI) (http://www.ahrq.gov/cpi/centers/cepi/index.html) generates new knowledge, synthesizes evidence, translates science on what works in health and health care delivery, and catalyzes practice improvement across health care settings.

Related HRSA Resources
- The ECRI Institute Clinical Risk Management Program[4] provided on behalf of HRSA (https://www.ecri.org/components/hrsa/Pages/default.aspx) (free login required)
- HRSA Quality Improvement resources (http://www.hrsa.gov/quality/index.html)
- HRSA Quality Improvement & Risk Management Training (http://www.hrsa.gov/publichealth/guidelines/qualityimprovement.html), see
  - Maximizing the Effectiveness of Quality Improvement Plans
  - How to Leverage Resources to Design a Successful Health Center Quality Improvement Program
  - Tips for Implementing Your Quality Improvement Program
- HRSA Accreditation and Patient-Centered Medical Home Recognition Initiative (http://bphc.hrsa.gov/qualityimprovement/clinicalquality/accreditation-pcmh/index.html)

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- Federal Tort Claims Act (FTCA) Risk Management and Quality Improvement (http://bphc.hrsa.gov/ftca/riskmanagement/index.html)
- Federal Tort Claims Act Health Center Policy Manual (http://bphc.hrsa.gov/ftca/healthcenters/ftcahcpolicymanual.html) (if applicable)
- As a self-assessment tool, please refer to the Program Requirement 8: Quality Improvement/Assurance Plan section, page 15, of the Health Center Program Site Visit Guide (http://bphc.hrsa.gov/programrequirements/centerguide.html).

Section III: Management and Finance

Program Requirement 9: Key Management Staff

Requirement
Health center maintains a fully staffed health center management team as appropriate for the size and needs of the center. Prior approval by HRSA of a change in the Project Director/Executive Director/CEO position is required.

Documents/Resources to Review
- Health center organizational chart
- Key management staff position descriptions and biographical sketches
- Key management vacancy announcements (if applicable)
- Health center's official scope of project for services and sites (Form 5A and Form 5B)

Related HRSA Resources
As a self-assessment tool, please refer to the Program Requirement 9: Key Management Staff section, page 18, of the Health Center Program Site Visit Guide (http://bphc.hrsa.gov/programrequirements/centerguide.html).

Program Requirement 10: Contractual/Affiliation Agreements

Requirement
Health center exercises appropriate oversight and authority over all contracted services, including assuring that any subrecipient(s) meets Health Center program requirements.

Documents/Resources to Review
- Uniform Administrative Requirements for HHS Awards (45 CFR 75) (http://www.ecfr.gov/cgi-bin/text-idx?SID=e9e43be8e59e0a85f4ac8ee5b8ef7716&node=pt45.1.75&rgn=div5)
- Contract(s) or sub-award(s) (subrecipient agreements) for a substantial portion of the health center project
- Memorandum of Understanding (MOU)/Agreement (MOA) for a substantial portion of the health center project
- Contract with another organization for core primary care providers
- Contract with another organization for staffing the health center including any contracted key management staff (e.g. CEO, CMO, CFO)
- Any other key affiliation agreements, if applicable
- Procurement and/or other policies and/or policies and/or procedures that support oversight of contracts or affiliation
- Your grant application's Form 8: Health Center Agreements (http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP/forms/8affiliationcertification.docx) contains your existing agreements with other entities. This version is for reference purposes only.

Related HRSA Resources
- Affiliation Agreement Policies
  - PIN 97-27: Affiliation Agreements of Community and Migrant Health Centers (http://bphc.hrsa.gov/programrequirements/policies/pin199727.html)
  - PIN 98-24: Amendment to PIN 97-27 Regarding Affiliation Agreements of Community and Migrant Health Centers (http://bphc.hrsa.gov/programrequirements/policies/pin199824.html)
- PAL 2011-02: Health Center Collaboration (http://bphc.hrsa.gov/programrequirements/policies/pal201102.html)
- As a self-assessment tool, please refer to the Program Requirement 10: Contractual/Affiliation Agreements section, page 19, of the Health Center Program Site Visit Guide (http://bphc.hrsa.gov/programrequirements/centerguide.html).

Program Requirement 11: Collaborative Relationships

Requirement
Health center makes effort to establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center. The health center secures letter(s) of support from existing health centers (section 330 grantees and look-alikes) in the service area or provides an explanation for why such letter(s) of support cannot be obtained.

Documents/Resources to Review
- Letters of Support
- Memoranda of Agreement/Understanding
- Other relevant documentation of collaborative relationships
- UDS Mapper (http://www.udsmapper.org/)

Related HRSA Resources
- PAL 2011-02: Health Center Collaboration (http://bphc.hrsa.gov/programrequirements/policies/pal201102.html)
- As a self-assessment tool, please refer to the Program Requirement 11: Collaborative Relationships section, page 20, of the Health Center Program Site Visit Guide (http://bphc.hrsa.gov/programrequirements/centerguide.html).

Program Requirement 12: Financial Management and Control Policies

Requirement

Health center maintains accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and separates functions appropriate to organizational size to safeguard assets and maintain financial stability. Health center assures an annual independent financial audit is performed in accordance with Federal audit requirements, including submission of a corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the audit report.

Documents/Resources to Review

- Uniform Administrative Requirements for HHS Awards (45 CFR 75) (http://www.ecfr.gov/cgi-bin/text-idx?SID=e9e43be8e59e0a85f4ac8ee5b8ef7716&node=pt45.1.75&rgn=div5)
- Office of Management and Budget Circular A-133 (https://www.whitehouse.gov/omb/circulars_a133-lead/)
- Most recent independent financial audit and management letter, including audit corrective action plans based on prior year audit findings, if applicable
- Most recent monthly financial statements if a first audit has not been completed
- Financial management/accounting and internal control policies and/or procedures
- Chart of accounts
- Balance sheet
- Income statement
- Most recent Health Center Program required financial performance measures/UDS Report

Related HRSA Resources

- HRSA Federal Financial Report (FFR) resources (http://www.hrsa.gov/grants/manage/)
- PIN 2013-01: Health Center Budgeting and Accounting Requirements (http://bphc.hrsa.gov/programrequirements/policies/pin201301.html)
- As a self-assessment tool, please refer to the Program Requirement 12: Financial Management and Control section, page 21, of the Health Center Program Site Visit Guide (http://bphc.hrsa.gov/programrequirements/centerguide.html).

Program Requirement 13: Billing and Collections

Requirement
Health center has systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures.

Documents/Resources to Review
- Policies and/or procedures for billing and collection
- Encounter form(s)
- Third party payor contracts
- Most recent UDS Report
- Additional information on the Affordable Care Act can be found at http://healthcare.gov. Resources for consumers and providers are available as well as links to additional health insurance program information including Medicare and Medicaid
- CMS Federally Qualified Health Centers (FQHC) Center (https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html)
- The Samples and Templates Resource Center[5] Management and Finance page, see Billing Collections (http://bphc.hrsa.gov/programrequirements/resourcecenter/managementandfinance/index.html#Billing%20Collections)

Related HRSA Resources
- PIN 2014-02: Sliding Fee Discount and Related Billing and Collections Program Requirements (http://bphc.hrsa.gov/programrequirements/policies/pin201402.html)
- PAL 2011-04: Process for Becoming Eligible for Medicare Reimbursement under the FQHC Benefit (http://bphc.hrsa.gov/programrequirements/policies/pal201104.html)
- As a self-assessment tool, please refer to the Program Requirement 13: Billing and Collections section, page 23, of the Health Center Program Site Visit Guide (http://bphc.hrsa.gov/programrequirements/centerguide.html).

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Program Requirement 14: Budget

Requirement
Health center has developed a budget that reflects the costs of operations, expenses, and revenues (including the Federal grant) necessary to accomplish the service delivery plan, including the number of patients to be served.

Documents/Resources to Review
- Annual budget
- Most recent Income Analysis (Form 3)
- Most recent Staffing Profile
- The Samples and Templates Resource Center[6] Management and Finance page, see Financial Management (http://bphc.hrsa.gov/programrequirements/resourcecenter/managementandfinance/index.html#Financial%20Management)

Related HRSA Resources
- HRSA Federal Financial Report (FFR) resources (http://www.hrsa.gov/grants/manage/)
- PIN 2013-01: Health Center Budgeting and Accounting Requirements (http://bphc.hrsa.gov/programrequirements/policies/pin201301.html)
- As a self-assessment tool, please refer to the Program Requirement 14: Budget section, page 25, of the Health Center Program Site Visit Guide (http://bphc.hrsa.gov/programrequirements/centerguide.html).

Note: Beginning with applications for fiscal year 2014 funding, HRSA requires that along with a total budget, which includes a budget breakdown of all health center scope of project funding, grantees must also submit a separate budget breakdown for the Health Center Program funds and non-grant funds proposed for the application period. That is, the budget must show which costs are supported by the section 330 grant and which projected costs are supported by other non-grant funds. HRSA will allow individual health centers discretion regarding how they propose to allocate the total budget between section 330 grant funds and non-grant funds, provided the budgeting complies with all applicable HHS policies. The requirement for a separate Federal budget breakdown is not applicable to look-alikes.

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Program Requirement 15: Program Data Reporting Systems

Requirement
Health center has systems which accurately collect and organize data for program reporting and which support management decision making.

Documents/Resources to Review
- Most recent UDS report and UDS Health Center Trend Report
- Most recent Clinical and Financial Performance Measures Forms
- Clinical and financial information systems (e.g. EHR, practice management systems, billing systems)
- National Association of Community Health Centers, Business Planning Guide for Community Health Centers[7] (http://www.nachc.com/client/documents/health-center-information/health-center-growth/BusinessPlanTemplate.pdf)

Related HRSA Resources
- HRSA Federal Financial Report (FFR) resources (http://www.hrsa.gov/grants/manage/)
  - o Federal Financial Report (FFR) Quick Guide (http://www.hrsa.gov/grants/manage/technicalassistance/federalfinancialreport/ffrquickguide.pdf)
    - ▪ In addition, an audio replay and transcript of an FFR training session is available on the HRSA Grants Web page (http://www.hrsa.gov/grants/manage/index.html).
- Health Center Program Clinical and Financial Performance Measures (http://bphc.hrsa.gov/qualityimprovement/performancemeasures/index.html)
- Health Center Program grantee data (http://bphc.hrsa.gov/uds/datacenter.aspx?q=d&year=2013)
- Uniform Data System (UDS) Resources (http://bphc.hrsa.gov/datareporting/reporting/index.html)
- As a self-assessment tool, please refer to the Program Requirement 15: Program Data Reporting Systems section, page 26, of the Health Center Program Site Visit Guide (http://bphc.hrsa.gov/programrequirements/centerguide.html).

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Program Requirement 16: Scope of Project

Requirement
Health center maintains its funded scope of project (sites, services, service area, target population, and providers), including any increases based on recent grant awards.

Documents/Resources to Review
- Most recent Health Center UDS Trend Report
- Health center's official scope of project for sites and services (Forms 5A, 5B, and 5C) and plan to verify sites and services within 120 days of award
- Most recent Form 2: Staffing Profile
- Notice of Award and information for any recent New Access Point or other supplemental grant awards

Related HRSA Resources
- Scope of Project information and policies (http://bphc.hrsa.gov/programrequirements/scope.html)
- PIN 2008-01: Defining Scope of Project and Policy for Requesting Changes (http://bphc.hrsa.gov/programrequirements/policies/pin200801.html)
- PIN 2009-02: Specialty Services and Health Centers' Scope of Project (http://bphc.hrsa.gov/programrequirements/pdf/pin200902.pdf)
- PIN 2009-05: Policy for Special Populations-Only Grantees Requesting a Change in Scope to Add a New Target Population (http://bphc.hrsa.gov/programrequirements/policies/pin200905specialpops.html)
- PAL 2013-03: Alignment of EHB Change in Scope Module with Change in Scope Policy, and printable previews of Scope Forms and Checklists (http://bphc.hrsa.gov/programrequirements/policies/pal201303.html)
- PAL 2014-10: Updated Process for Change in Scope Submission, Review and Approval Timelines (http://bphc.hrsa.gov/programrequirements/policies/pal201410.html)
- Uniform Data System (UDS) Resources (http://bphc.hrsa.gov/datareporting/reporting/index.html)
- As a self-assessment tool, please refer to the Program Requirement 16: Scope of Project section, page 27, of the Health Center Program Site Visit Guide (http://bphc.hrsa.gov/programrequirements/centerguide.html).

Section IV: Governance

Program Requirement 17: Board Authority

Requirement
Health center governing board maintains appropriate authority to oversee the operations of the center, including:

- Holding monthly meetings;
- Approval of the health center grant application and budget;
- Selection/dismissal and performance evaluation of the health center CEO;
- Selection of services to be provided and the health center hours of operations;
- Measuring and evaluating the organization's progress in meeting its annual and long-term programmatic and financial goals and developing plans for the long-range viability of the organization by engaging in strategic planning, ongoing review of the organization's mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance; and
- Establishment of general policies for the health center.

Note: In the case of public centers (also referred to as public entities) with co-applicant governing boards, the public center is permitted to retain authority for establishing general policies (fiscal and personnel policies) for the health center.

Note: Look-alikes may not be owned, controlled, or operated by another entity; therefore, parent-subsidiary arrangements, network corporations, etc., may not be eligible for designation.

Documents/Resources to Review
- Organization /corporate bylaws
- Minutes of recent board meetings
- Health center policies and/or procedures
- Board annual meeting schedule
- If applicable, Co-Applicant Agreement for public centers
- List of board committees
- Your grant application's Form 6A: Current Board Member Characteristics (http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP/forms/6aboardmember.DOCX) contains basic information on your board structure. This version is for reference purposes only.
- The Samples and Templates Resource Center[8]
    - Governance page, see Board Authority (http://bphc.hrsa.gov/programrequirements/resourcecenter/governance/index.html#boardauthority)

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[8] *Note: All non-Federal documents are for use as aids to consultants and grantees, the contents of such documents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA, and should not be considered official guidance by BPHC. Any "sample" documents must be tailored to the health center's unique circumstances and needs.*

- o Board Functions and Responsibilities
  (http://bphc.hrsa.gov/archive/technicalassistance/resourcecenter/governance/boardfunctionsandresponsibilities.pdf)
- o Management and Finance page, see Financial Management "Board and Management Reports"
  (http://bphc.hrsa.gov/archive/technicalassistance/resourcecenter/managementandfinance/boardandmanagementreports.pdf)

Related HRSA Resources

- PIN 2014-01: Health Center Program Governance
  (http://bphc.hrsa.gov/programrequirements/policies/pin201401.html)
- As a self-assessment tool, please refer to the Program Requirement 17: Board Authority section, page 29, of the Health Center Program Site Visit Guide
  (http://bphc.hrsa.gov/programrequirements/centerguide.html).

Program Requirement 18: Board Composition

Requirement
The health center governing board is composed of individuals, a majority of whom are being served by the center and, this majority as a group, represent the individuals being served by the center in terms of demographic factors such as race, ethnicity, and sex. Specifically:
- Governing Board has at least 9 but no more than 25 members, as appropriate for the complexity of the organization.
- The remaining non-consumer members of the board shall be representative of the community in which the center's service area is located and shall be selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community.
- No more than one half (50%) of the non-consumer board members may derive more than 10% of their annual income from the health care industry.

Note: Upon a showing of good cause the Secretary may waive, for the length of the project period, the patient majority requirement in the case of a health center that receives a grant pursuant to subsection (g), (h), (i), or (p).

Documents/Resources to Review
- Composition of board of directors/most recent Form 6A: Current Board Member Characteristics (http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP/forms/6aboardmember.DOCX)
- Organizational/corporate bylaws
- Board member application and disclosure forms
- If applicable, Form 6B: Request for Waiver of Governance Requirement (http://bphc.hrsa.gov/programopportunities/fundingopportunities/sac/form6b.docx)
- UDS Summary Report
- Health Center New Access Point Grant Application Technical Assistance page (http://bphc.hrsa.gov/programopportunities/fundingopportunities/NAP/index.html)
- The Samples and Templates Resource Center[9] Governance page, see Board Composition (http://bphc.hrsa.gov/programrequirements/resourcecenter/governance/index.html#boardcomposition)

Related HRSA Resources
- PIN 2014-01: Health Center Program Governance (http://bphc.hrsa.gov/programrequirements/policies/pin201401.html)
- As a self-assessment tool, please refer to the Program Requirement 18: Board Composition section, page 32, of the Health Center Program Site Visit Guide (http://bphc.hrsa.gov/programrequirements/centerguide.html).

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[9] *Note: All non-Federal documents are for use as aids to consultants and grantees, the contents of such documents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA, and should not be considered official guidance by BPHC. Any "sample" documents must be tailored to the health center's unique circumstances and needs.*

Program Requirement 19: Conflict of Interest Policy

Requirement
Health center bylaws or written corporate board approved policy include provisions that prohibit conflict of interest by board members, employees, consultants and those who furnish goods or services to the health center.
- No board member shall be an employee of the health center or an immediate family member of an employee. The Chief Executive may serve only as a non-voting ex-officio member of the board.

Documents/Resources to Review
- Uniform Administrative Requirements for HHS Awards (45 CFR 75) (http://www.ecfr.gov/cgi-bin/text-idx?SID=e9e43be8e59e0a85f4ac8ee5b8ef7716&node=pt45.1.75&rgn=div5)
- Corporate Bylaws
- Most recent update of Conflict of Interest policy and related procedures
- Procurement policies and procedures

Related HRSA Resources
- PIN 2014-01: Health Center Program Governance (http://bphc.hrsa.gov/programrequirements/policies/pin201401.html)
- As a self-assessment tool, please refer to the Program Requirement 19: Conflict of Interest Policy section, page 35, of the Health Center Program Site Visit Guide (http://bphc.hrsa.gov/programrequirements/centerguide.html).

Supporting Federal Programs

340B Drug Pricing Program

What is the 340B Drug Pricing Program?
HRSA's Office of Pharmacy Affairs (OPA) administers the 340B Drug Pricing Program. The 340B Program requires drug manufacturers to provide outpatient drugs to eligible health care organizations/covered entities at significantly reduced prices including section 330-funded health centers. Participation in the Program results in significant savings estimated to be 25 to 50 percent of what the entity would have otherwise paid. The purpose of the 340B Program is to enable these entities to stretch scarce Federal resources, reaching more eligible patients and providing more comprehensive services.

Related Legislation
The 340B Drug Pricing Program (http://www.hrsa.gov/opa/index.html) resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act.

How to Enroll
To enroll in the 340B Program, health centers must submit the appropriate registration information to the HRSA Office of Pharmacy Affairs. The on-line registration is located at http://opanet.hrsa.gov/340B/Default.

340B Prime Vendor Program
In addition to savings available through the 340B Program, the 340B Prime Vendor Program (PVP) provides additional savings to 340B participants registered with the Prime Vendor. The PVP provides drug distribution and price negotiation services for covered entities, and has been able to negotiate additional discounts below the 340B price for more than 2,800 brand name and generic drugs.

The PVP is free to all 340B covered entities, but the covered entity must enroll in the PVP.
- For more information, call 1-888-340-2787 or visit https://www.340bpvp.com/controller.html.
- Note that the NoA contains the following term regarding grantee responsibility on this topic: "If your organization purchases or reimburses for outpatient drugs, an assessment must be made to determine whether the organization drug acquisition practices meet Federal requirements regarding cost-effectiveness and reasonableness.
  If your organization is eligible to be a covered entity under Section 340B of the Public Health Service Act and the assessment shows that participating in the 340B Drug Pricing Program and its Prime Vendor Program is the most economical and reasonable manner of purchasing or reimbursing for covered outpatient drugs (as defined in Section 340B), failure to participate may result in a negative audit finding, cost disallowance or grant funding offset."
  [See 42 CFR Part 50, Subpart E, and OMB Circulars A-122 (https://www.whitehouse.gov/omb/circulars_a122_2004/) and A-87 (https://www.whitehouse.gov/omb/circulars_a087_2004) regarding cost principles.]

Links and Additional Resources
- HRSA Office of Pharmacy Affairs - 340B Program website (http://www.hrsa.gov/opa/index.html)

- 340B Prime Vendor: Email: ApexusAnswers@340bpvp.com. Phone: 1-888-340-2787. Chat live at https://apexuschat.alliancewebs.net/WebChat/Main.aspx?QueueName=APEXUSANSWERSWEBCHAT (8:30 a.m. to 6:30 p.m. ET, Monday through Friday)

Federal Tort Claims Act

What is the Federal Tort Claims Act (FTCA)?
The Federally Supported Health Centers Assistance Act of 1992 and 1995, granted medical malpractice liability protection through the Federal Tort Claims Act (FTCA) to HRSA-supported health centers. FTCA is the legal mechanism for compensating people who have suffered personal injury by the negligent or wrongful action of employees of the U.S. government.
- Under the Act, health centers are considered Federal employees and are immune from lawsuits, with the Federal government acting as their primary insurer.
- There is no cost to participating health centers or their providers, and they are not liable for any settlements or judgments that are made. The Federal government assumes responsibility for these costs.

Eligibility
- Employees of eligible health centers may be deemed to be Federal employees qualified for protection.
- Eligible health centers must submit an original deeming and annual renewal deeming application to BPHC.
- FTCA coverage is not assured from year to year. Each year, health centers are approved after they demonstrate that they meet all the requirements of the FTCA program.

Covered Activities
Covered activities are acts or omissions in the performance of medical, surgical, dental, or related functions resulting in personal injury, including death, and occurring within the scope of employment. More specifically, covered activities include those activities that:
- Are approved within each covered individual's scope of employment (this term includes activities within an applicable individual contract for services with the health center);
- Are within the scope of the approved Federal section 330 grant project of the deemed health center; and
- Take place during the provision of services to health center patients and, in certain circumstances, to non-health center patients.

Claims
A patient who alleges acts of medical malpractice by a deemed health center, for covered activities, cannot sue the center or the provider directly, but must file an administrative claim with the appropriate agency of the Federal government before filing suit.
- FTCA litigation must be filed in a Federal district court.
- These claims are reviewed and/or litigated by the U.S. Department of Health and Human Services, Office of the General Counsel and the Department of Justice according to FTCA requirements.
- HRSA pays for all settlements and judgments from a separately appropriated Health Center FTCA Judgment Fund.
- To learn how your health center can become deemed under FTCA, go to http://bphc.hrsa.gov/ftca/healthcenters/hcappprocess.html.

Links and Additional Resources
- Federal Tort Claims Act (FTCA) (http://bphc.hrsa.gov/ftca/index.html)
- HRSA EHB User Guide: FTCA User Guide for Grantees (http://bphc.hrsa.gov/ftca/pdf/ftcauserguide.pdf)
- FTCA Policies for Health Centers (http://bphc.hrsa.gov/ftca/healthcenters/healthcenterpolicies.html)
- For more information, please contact the BPHC Helpline at 1-877-974-BPHC (2742) or http://www.hrsa.gov/about/contact/bphc.aspx.

Related Legislation, Regulations, and Policies
Congress enacted FTCA medical malpractice protection for Federally-supported health centers through the Federally Supported Health Centers Assistance Act (FSHCAA) of 1992 (P.L. 102-501) and FHSCAA of 1995 (P.L. 104-73), later codified as 42 U.S.C. Section 233 (a) - (n).

HRSA/BPHC has issued numerous PINs and PALs related to FTCA. In 2014, HRSA released the Federal Tort Claims Act Health Center Policy Manual (http://bphc.hrsa.gov/ftca/healthcenters/ftcahcpolicymanual.html). The manual is the primary source for information on FTCA for Health Center Program grantees and related stakeholders. It consolidates all of the major FTCA PINs and PALs into one document.

National Health Service Corps

What is the National Health Service Corps (NHSC)?
The National Health Service Corps (NHSC) (http://nhsc.hrsa.gov/), through scholarship and loan repayment programs, helps Health Professional Shortage Areas (HPSAs) (http://www.hrsa.gov/shortage/) in the United States get the medical, dental, and mental health providers they need.
- Since 1972, more than 30,000 clinicians have served in the Corps, expanding access to health care services and improving the health of people who live in urban and rural areas where health care is scarce.
- About half of all NHSC clinicians work in HRSA-supported health centers, delivering preventive and primary care services to patients regardless of their ability to pay.
- Health Centers automatically qualify as NHSC sites.
- See the National Health Service Corps Site Reference Guide (http://nhsc.hrsa.gov/downloads/sitereference.pdf) on how to request a HPSA score and for more information.

Full- and Half-Time NHSC Opportunities
The NHSC offers both full- and half-time positions.
- Qualifying providers can search for all NHSC job opportunities at http://nhscjobs.hrsa.gov/external/search/index.seam.
- The Affordable Care Act contains provisions allowing current providers to convert from full-time to half-time. For more information on this opportunity, go to http://nhsc.hrsa.gov/loanrepayment/options.html.

Scholarship
The NHSC Scholarship (http://nhsc.hrsa.gov/scholarships/index.html) is a competitive program that pays tuition, fees, and provides a living stipend to students enrolled in accredited medical (MD or DO), dental, nurse practitioner, certified nurse midwife, and physician assistant training. Upon graduation, scholarship recipients serve as primary care providers between 2 and 4 years in a HPSA site that has applied to and been

approved by the NHSC as a service site. HRSA makes awards to applicants most committed to serving underserved people and most likely to build successful careers in HPSAs and meet future needs for care throughout the Nation.

Loan Repayment
The NHSC Loan Repayment Program (http://nhsc.hrsa.gov/loanrepayment/) offers fully trained primary care physicians (MD or DO), family nurse practitioners, certified nurse midwives, physician assistants, dentists, dental hygienists, and certain mental health clinicians $60,000 to repay student loans in exchange for 2 years serving in a community-based site in a high-need HPSA that has applied to and been approved by the NHSC as a service site. The loan repayment program recruits both clinicians just completing training and seasoned professionals to meet the immediate need for care throughout the Nation.

- After completing their 2 years of service, loan repayors may apply for additional years of support.

Links and Additional Resources
- NHSC website (http://nhsc.hrsa.gov/index.html)
- NHSC Loan Repayment Program (http://nhsc.hrsa.gov/loanrepayment/)

Health Information Technology and Meaningful Use

What is Health Information Technology?
Health IT is technology used to record, store, protect, retrieve, and transfer clinical, administrative, and financial information electronically within health care settings. Health IT is a tool by which clinicians and others can improve population health and the quality and efficiency of patient care. Recent research demonstrates that increased use of information technology is an important step in improving quality of care and patient safety.

- The term *Meaningful Use* is often used to refer to the EHR Incentive Program from the Centers for Medicare & Medicaid Services (CMS) and to the incentive payments. A provider must use health IT in a *meaningful* way (e.g., for e-prescribing) in order to be eligible for the payments.

HRSA's Vision for Health IT
HRSA's vision is to leverage the power of health IT to improve patient outcomes, quality, and reduce health disparities for people who are uninsured, isolated, or medically vulnerable.

- Health Centered Controlled Networks (http://www.hrsa.gov/healthit/networkguide/)
- Find a Health Centered Controlled Network (http://findanetwork.hrsa.gov/Search_OHIT.aspx)
- Organizations Safety Net Providers Can Collaborate With (http://www.hrsa.gov/healthit/toolbox/healthitimplementation/implementationtopics/collaborate/collaborate_3.html)

Health IT Importance and Financial Incentives
The American Recovery and Reinvestment Act (ARRA) made financial incentives (http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html) available to eligible professionals and hospitals for *Meaningful Use* of Electronic Health Records (EHRs).

- Per ARRA (http://www.recovery.gov/Pages/default.aspx), CMS makes incentive payments to individual providers, rather than to health centers.
  - o This is the case even if the health center paid the EHR-related expenses that resulted in the incentive payments.

BPHC Technical Assistance Web Guide for Grantees
Developed by the Health Resources and Services Administration
Last Updated: May 2015

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- o Providers may choose to give their incentive payments to their health center, through a process known as "assignment."
  - o However, providers are not required to assign their payments. Also, providers may use the payments for any purpose (professional or personal) they choose.
- Health Center providers are likely to apply for EHR incentive payments through Medicaid.
  - o Both Medicare and Medicaid offer incentive payments to eligible providers to use EHRs, but providers must choose to receive payments from only one of these programs.
  - o Because of reimbursements and the patient population typically served, health center providers are likely to apply for payments through Medicaid.
  - o To apply for the Medicaid EHR Incentive Program, contact your State Medicaid agency. The policies and timelines for applying vary by State.
- To qualify for Meaningful Use EHR Incentive Program payments, eligible professionals must use certified EHR technology.
  - o Working with CMS, the Office of the National Coordinator for Health IT (ONC) (http://www.healthit.gov/) has established standards for certifying EHRs.
  - o To receive incentive payments, eligible professionals must use an EHR that is certified (http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Certification.html) specifically for the EHR Incentive Program.
- AHRQ (http://www.ahrq.gov/?wtag=wtag80) funded the National Resource Center for Health IT (NRC) (http://healthit.ahrq.gov/) in 2004, and approximately $166 million in health IT projects throughout the United States.
- HRSA has supported the adoption of health IT by health centers, other safety net providers, and ambulatory care providers since the 1980s, through various grant programs ranging from operational funding to funding Health Center Controlled Networks (HCCNs) (http://bphc.hrsa.gov/programopportunities/fundingopportunities/default.aspx?id=5e636d73-87f7-4895-bbf3-e5dab4b74975) to improve quality through health IT.

Links and Additional Resources
- HHS Office of the National Coordinator for Health Information Technology (http://www.healthit.gov/)
- AHRQ PCMH Resource Center (http://www.pcmh.ahrq.gov/)
- AHRQ Report: D. Lipson, E. Rich, J. Libersky, M. Parchman. Ensuring That Patient-Centered Medical Homes Effectively Serve Patients With Complex Health Needs. (Prepared by Mathematica Policy Research under Contract No. HHSA290200900019I TO 2.) AHRQ Publication No. 11-. Rockville, MD: Agency for Healthcare Research and Quality. October 2011. (http://pcmh.ahrq.gov/page/ensuring-patient-centered-medical-homes-effectively-serve-patients-complex-health-needs)
- AHRQ Report: E.F. Taylor, T. Lake, J. Nysenbaum, G. Peterson, D. Meyers. Coordinating care in the medical neighborhood: critical components and available mechanisms. White Paper (Prepared by Mathematica Policy Research under Contract No. HHSA290200900019I TO2). AHRQ Publication No. 11-0064. Rockville, MD: Agency for Healthcare Research and Quality. June 2011. (http://pcmh.ahrq.gov/page/coordinating-care-medical-neighborhood-critical-components-and-available-mechanisms)
- Centers for Medicare & Medicaid Services EHR Incentive Programs (http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html)
- HRSA: Medicare and Medicaid EHR Incentive Programs FQHCs' FAQs (http://www.hrsa.gov/healthit/meaningfuluse/hrsa_cms_mu_stage_1_faqs_for_fqhcs.pdf)

- HRSA On-Demand Quality Improvement and Health IT Webinars (http://www.hrsa.gov/quality/)
- HRSA Health IT Resources & On-Demand Webinars (http://www.hrsa.gov/healthit/)
- HRSA Health IT Implementation Toolbox (http://www.hrsa.gov/healthit/toolbox/healthitimplementation/index.html)
- HRSA Health IT for Children's Health Toolbox (http://www.hrsa.gov/healthit/toolbox/Childrenstoolbox/index.html)
- Rural Health IT Adoption Toolbox (http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/index.html)
- HRSA Accreditation and Patient-Centered Medical Home Recognition Initiative (http://bphc.hrsa.gov/qualityimprovement/clinicalquality/accreditation-pcmh/index.html)
- HRSA Information Session: Many Paths to the Patient Centered Medical Home - Which One is Right for my Organization? (http://bphc.hrsa.gov/qualityimprovement/clinicalquality/accreditation-pcmh/accreditationwebinars.html) is a TA session recorded in May 2012.

Affordable Care Act

Newly funded grantees can learn more about the Affordable Care Act (ACA) and its impact on health centers by reading through the Provider Toolkit on the Affordable Care Act and HRSA Programs Web page (http://www.hrsa.gov/affordablecareact/index.html). The toolkit is a compilation of resources put together by HRSA and includes:

- ACA basics
- Education ACA materials for patients
- ACA impact on health center's as employers and businesses
- Training materials for health center staff

Additionally, you can read about health centers and the Affordable Care Act (http://bphc.hrsa.gov/about/healthcentersaca/index.html) or a fact sheet specific to the ACA's impacts on the Health Center Program mission, funding, and activities (http://bphc.hrsa.gov/about/healthcentersaca/healthcenterfactsheet.pdf).

The 2016 Marketplace Open Enrollment period will begin November 1, 2015, and continue through January 31, 2016. Between now and the 2016 Open Enrollment periods, there are Special Enrollment Periods (SEPs) available for some individuals to sign up for coverage in the marketplace. SEPs are permitted for individuals with extenuating circumstances surrounding tax filing, as well as for individuals with qualifying life events.

HRSA expects health centers to engage in outreach and enrollment efforts in their community. The Health Center Outreach and Enrollment (O/E) Assistance Web page (http://bphc.hrsa.gov/about/healthcentersaca/outreachenrollment/index.html) provides webinars, FAQs, and other information to assist health centers in this task.

Appendix

BPHC Acronyms

A
AAAHC	Accreditation Association for Ambulatory Health Care
AAPCHO	Association of Asian Pacific Community Health Organizations
ACA	Affordable Care Act
ACU	Association of Clinicians for the Underserved, Inc.
AHEC	Area Health Education Center
ARRA	American Recovery and Reinvestment Act
ASPR	Assistant Secretary for Preparedness and Response (HHS)
ASTHO	Association of State and Territorial Health Officials

B
BPHC	Bureau of Primary Health Care (HRSA)
BHW	Bureau of Health Workforce
BPR	Budget Period Renewal

C
CA	Cooperative Agreement
CAH	Critical Access Hospital
CAN	Common Accounting Number
CD	Capital Development
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CHC	Community Health Center
CHPFS	Community Health Partners for Sustainability
CIHS	Center for Integrated Health Solutions (SAMHSA/HRSA)
CIO	Chief Information Officer
CIS	Change in Scope
CMS	Centers for Medicare & Medicaid Services (HHS)
CSH	Corporation for Supportive Housing
CY	Calendar Year

D
DFI	Division of Financial Integrity (HRSA)
DGMO	Division of Grants Management Operations (HRSA)

E
EHB	Electronic Handbooks
EHR/EMR	Electronic Health Record/Electronic Medical Record
EMC	Expanded Medical Capacity
ES	Expanded Services

F

FFR	Federal Financial Report
FIP	Facility Investment Program awards
FJ	Farmworker Justice
FLEX	Medicare Rural Hospital Flexibility Grant Program
FLRP	Faculty Loan Repayment Program
FOA	Funding Opportunity Announcement
Form 5A	Form 5A: Services Provided
Form 5B	Form 5B: Service Sites
Form 5C	Scope of Project Form 5C: Other Activities/Locations
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FRN	Federal Register Notice
FTCA	Federal Tort Claims Act
FTE	Full Time Equivalent
FY	Fiscal Year

G

GMS	Grants Management Specialist
GMO	Grants Management Officer

H

HAB	HIV/AIDS Bureau (HRSA)
HC	Health Center
HCCN	Health Center Controlled Network
HHS	Department of Health and Human Services
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HOP	Health Outreach Partners
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
HSB	Healthcare Systems Bureau (HRSA)

I

IHS	Indian Health Service (HHS)

L

LGBT	Lesbian Gay Bisexual Transgender
LRP	Loan Repayment Program

M

MCHB	Maternal and Child Health Bureau (HRSA)
MCN	Migrant Clinicians Network
MHC	Migrant Health Center
MHP	Migrant Health Promotion
MIS	Management Information System

MOU/MOA	Memorandum of Understanding/Agreement
MSFW	Migrant and Seasonal Farmworker
MU	Meaningful Use
MUA	Medically Underserved Area
MUP	Medically Underserved Population

N

NACHC	National Association of Community Health Centers
NAM	North American Management
NAP	New Access Point
NASBHC	National Assembly on School-Based Health Care
NCA	National Cooperative Agreement
NCFH	National Center for Farmworker Health
NCQA	National Committee for Quality Assurance
NDA	Notice of Deeming Action (with FTCA)
NELRP	Nursing Education Loan Repayment Program
NHAS	National HIV/AIDS Strategy
NHCHC	National Health Care for the Homeless Council
NHSC	National Health Service Corps (HRSA)
NHSC LRP	National Health Service Corps Loan Repayment Program
NHSC SP	National Health Service Corps Scholarship Program
NNOHA	National Network for Oral Health Access
NoA	Notice of Award
NOSORH	National Organization of State Offices of Rural Health
NPRM	Notice of Proposed Rulemaking
NPDB	National Practitioner Databank (HRSA)

O

OAA	Office of the Associate Administrator (BPHC)
OASH	Office of the Assistant Secretary for Health (HHS)
OC	Office of Communications (HRSA)
OCR	Office for Civil Rights (HHS)
O/E	Outreach and Enrollment
OFAM	Office of Federal Assistance Management (HRSA)
OGC	Office of the General Counsel (HHS)
OIG	Office of the Inspector General (HHS)
OMB	Office of Management and Budget
ONC	Office of the National Coordinator for Health Information Technology (HHS)
ONAP	Office of National AIDS Policy
ONHS	Office of Northern Health Services (BPHC, HRSA)
OPAE	Office of Planning, Analysis and Evaluation (HRSA)
OPPD	Office of Policy and Program Development (BPHC, HRSA)
OQI	Office of Quality Improvement (BPHC, HRSA)
ORHP	Office of Rural Health Policy (HRSA)
ORO	Office of Regional Operations (HRSA)
OSBO	Office of Strategic Business Operations (BPHC, HRSA)

OSD	Office of Shortage Designation (BHW, HRSA)
OSHS	Office of Southern Health Services (BPHC, HRSA)
OTC	Over the Counter

P

PAC	Progressive Action Condition
PAL	Program Assistance Letter
PAR	Program Analysis and Recommendation
PD	Position Description
PCA	Primary Care Association
PCO	State Primary Care Office
PCMH	Patient-Centered Medical Home
PHPC	Public Housing Primary Care
PHS	Public Health Service
PIN	Policy Information Notice
PMM	Project Management Module (EHB)
PMS	Payment Management System
PO	Project Officer

Q

| QA | Quality Assurance |
| QI | Quality Improvement |

R

RAC	Rural Assistance Center
REC	Regional Extension Center
RHC	Rural Health Clinic
RHN	Rural Health Network
3RNet	National Rural Recruitment and Retention Network
R&R	Recruitment and Retention
RRC	Rural Referral Center
RTSC	Recruitment Training and Support Center

S

SAC	Service Area Competition
SAMHSA	Substance Abuse and Mental Health Services Administration (HHS)
SBHA	School-Based Health Alliance
SBHC	School-Based Health Center
SCHIP	State Children's Health Insurance Program
SEARCH	Student/Resident Experiences and Rotations in Community Health
Section 330	Section 330 of the Public Health Service Act Statute
SG	Surgeon General of the United States
SLRP	State Loan Repayment Program
SORH	State Offices of Rural Health

T

TA   Technical Assistance
TJC   The Joint Commission

U

UDS   Uniform Data System

BPHC Organizational Chart

(http://bphc.hrsa.gov/about/careeropportunities/bphcorganizationchart.pdf)